A Report of the Governor's Mental Health Services Planning Council

Mental Health Parity Task Force

2006

Task Force Mission

Study The Barriers To Coverage, In A State-regulated Insurance Plan, That Exist Under The Current Mental Health Parity Law.

Mental Health Insurance Parity

Insurance coverage and administration that is equal to, but not superior to, other medical conditions such as cancer, diabetes or heart disease.

***Mental Health: A Report Of The Surgeon General* (1999)**

"The Distinction Between Mental And Somatic Disorders Is The Locus Of The Predominant Symptoms."

"Mental And Physical Disorders Are Equally Valid Parts Of The *Continuum Of Function*."

Why Parity?

- Mental disorders and physical disorders are only different in the way that they are experienced.
- Mental health is fundamental to overall health.
- Mental disorders are as disabling as cancer and heart disease in terms of premature death and lost productivity.

Impact Of Inequality

- **Stigma of mental illness reinforced.**
- **5.6 million adults reported unmet mental health treatment needs and 47.2% of them said it was because of cost and/or insurance issues.**
- **Cost shifting to the public sector.**
- **Increased use of medical services and sick time.**
- **Families with good heath insurance cannot afford appropriate treatment for debilitating and sometimes fatal disorders.**

PARITY IS AFFORDABLE

On Tuesday, James Purcell, chief executive of Blue Cross Blue Shield of Rhode Island, said a similar effort to bring equal status to mental health coverage in Rhode Island "didn't break the bank."

Still, Purcell said, there is not full parity on office visits in Rhode Island, so the annual number of office visits a person can make for mental health care can be restricted — a policy he called bad medicine, bad law and bad insurance.

"Who are the people that are most likely going to need those extra visits? They're people who are really in tough shape," he said. "Where do they end up? In the emergency room."

He said Blue Cross Blue Shield of Rhode Island supported mental health parity.

U.S. House Of Representatives / Mental health parity pursued
Associated Press
BY MICHELLE R. SMITH
Wed, Jan. 17, 2007

SOME COST STUDIES

- Parity would increase premiums by only 1.4 to 1.6 percent. Kirschstein (2000).
- The average annual premium increase associated with mental health parity predicted to cost only 1.4%. The Hay Group (2000).
- After one year Minnesota BC/BC reduced premiums five to six percent under a comprehensive parity law.
- North Carolina reduced MH expenses since it passed full parity in 1992.
- When employers offered broad mental health benefits, the costs for medical-surgical treatment for employees was reduced by 20%. Chiles, et al. (1999).

INSURANCE COVERAGE FOR SERVICES RENDERED IN TREATMENT OF ALCOHOLISM, DRUG ABUSE OR NERVOUS OR MENTAL CONDITIONS (KSA 40-2,105)

- Applies to nervous and mental conditions not covered by the parity act
- Availability of not less than 30 inpatient days per year
- Reimbursement for outpatient treatment of not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1640 per year
- Lifetime limit of $7500

KANSAS MENTAL HEALTH PARITY ACT (KSA 40-2,105a)

- Definition of mental illness includes a limited number of the mental disorders found in the Diagnostic and Statistical Manual IV-TR (2000)
- Requires availability of 45 inpatient days per year and 45 outpatient visits per year

BARRIERS TO ACHIEVING THE INTENT OF THE CURRENT STATUTES

- No Kansas administrative regulations
- Inconsistent utilization review focused on output rather than outcome variables
- Inadequate protection of confidentiality in reporting requirements
- Discriminatory gate keeping
- Required grading of the severity of the mental illness
- Discrimination in the treatment of severe, chronic, and recurrent mental illness
- Relevant, valid, and reliable UR data are inaccessible

TASK FORCE RECOMMENDATIONS REGARDING AMENDMENTS TO THE STATUTES

- Delete the annual 45 day in-patient and 45 visit outpatient limit from KSA 40-2,105a.
- Remove disparate co-payments, annual limits, and lifetime maximum from KSA 40-2,105.
- Require reimbursement or indemnification of the full continuum of care for psychiatric illnesses just as for physical illnesses.
- Require insurers to provide maintenance therapy and support.
- Disallow disparate authorization, monitoring, and compensation of treatment.
- Require coverage of all DSM-IV-TR mental disorder diagnoses unless the same criteria used to exclude a somatic disorder have been applied.
- Require that all information related to a diagnosed mental disorder and its treatment be protected from potential data mining.
- Require that mental health treatment modalities covered by insurers include preventive care.

Task Force Recommendations Regarding Regulations

- Promulgate regulations assuring compliance of insurers with both the letter and intent of the parity statutes.
- Require uniform application of UR definitions, criteria, policies, and procedures that are neither more nor less restrictive than those applied to general health.
- Base UR criteria on clinical need determined by a practitioner licensed by the Behavioral Sciences Regulatory Board or the Board of Healing Arts.
- Make UR criteria accessible to both the insured and the insured's service provider.
- Develop uniform criteria for access to in-patient treatment that are no more stringent than those applied to somatic disorders.
- Require insurers to base decisions about continuing in-patient or outpatient treatment on research-based clinical outcome criteria.
- Convene an expert panel of stakeholders to recommend a process for acquisition of relevant, valid, reliable, and easily accessible data that can be used to monitor compliance with KSA 40-2, 105, 105a and 2258.
- Assure that treatment reimbursement decisions are guided by scientific research.